City of Montgomery

Mental Health and Substance Abuse Benefits Handbook

Effective June 1, 2020, Through May 31,2021

Important Information

The benefits described in this *Mental Health and Substance Abuse Benefits Handbook* (*Handbook*) are provided in conjunction with the *City of Montgomery Group Health Plan*. Please refer to the *City of Montgomery Group Health Plan* booklet for important additional information such as eligibility, enrollment, privacy, and security of your protected health information, and COBRA rights. To the extent that the benefits described in this *Handbook* and the *City of Montgomery Group Health Plan* are subject to the *Employee Retirement Income Security Act of 1974* (ERISA), this *Handbook* is considered to be a supplement to the *City of Montgomery Health Plan Summary Plan Description* (SPD), which may be the same document as the group health plan booklet discussed above.

This is not an insured benefit plan. The mental health and substance abuse benefits described in this *Handbook* are funded by the City of Montgomery. American Behavioral provides utilization management, claims administration, and provider network services to the plan, but American Behavioral does not insure the benefits described in this *Handbook*.

Mental Health Parity and Addiction Equity Act

Every effort is made to ensure that this *Mental Health and Substance Abuse Benefits Handbook* complies with the requirements of the *Mental Health Parity and Addiction Equity Act* (Parity). However, if we determine that a provision does not comply with Parity or there are legislative or regulatory changes to Parity rules, we may immediately implement benefit changes that are not reflected in this *Handbook*.

Welcome Employees and Family Members

We are pleased that the City of Montgomery has selected American Behavioral to serve as your behavioral health care benefits administrators.

Managed Behavioral Healthcare Services

A managed behavioral healthcare program is available to provide additional resources when needed. It is a program of care designed to provide disorder identification, clinical treatment referrals, and crisis intervention for employees and family members who experience clinical mental health or behavioral conditions such as:

- Adjustment disorders
- Attention deficit disorder
- Anxiety disorders
- Mood disorders
- Alcohol and/or substance abuse disorders

American Behavioral has a large network of providers who are credentialed in a variety of areas to meet your needs and provide clinical assistance in your area of concern. Providers include psychiatrists, psychologists, nurse practitioners, clinical social workers and licensed professional counselors, among others.

The following levels of care are available through this program:

- Crisis assessment
- Outpatient treatment
- Intensive outpatient treatment program
- Partial hospitalization/day treatment program
- Acute psychiatric inpatient hospitalization
- Detoxification services
- Electroconvulsive therapy
- Care management.

This document contains valuable information about the specific benefits available through your program along with descriptions and definitions of available services. We look forward to assisting you in your behavioral health care needs.

Table of Contents

Important Contact Information

Do You Have Questions?

Please call American Behavioral at 1-800-677-4544 for assistance with any questions you have concerning the provisions outlined in this *Handbook*. If needed, a translation service will be available to assist you.

TTY Services for the Hearing or Speech Impaired

Call the Nationwide Relay Service at 711.

Corporate Headquarters

2204 Lakeshore Drive, Suite 135
Birmingham, Alabama 35209

Telephone: 1-205-871-7814
Toll Free: 1-800-677-4544

Main Fax: 1-205-868-9600
Clinical Services Fax: 1-205-868-9625

Web Site

www.americanbehavioral.com

On Line Mental Health Appointment Requests

www.americanbehavioral.com

Finding a Behavioral Health Care Provider

How to Find a Network Provider

As an American Behavioral member, you have access to a network of providers. To find a network provider, call American Behavioral at 1-800-677-4544.

Using Out-of-Network Providers Costs You Money

IMPORTANT: Out-of-network providers do not have an agreement with the *Plan*, so you could be responsible in part or in full for the cost of the services provided.

If you plan to receive services from an out of network provider, you can request estimate of your out-of-pocket costs by calling American Behavioral at 1-800-677-4544 before services are rendered. This is just an estimate. The actual amount paid by the *Plan* will depend on the facts presented after the services or treatments have been rendered.

Covered Provider Types

The *Plan* pays for covered services only when performed by the following covered provider types:

Mental Health

- Licensed clinical therapists;
- Neuropsychologists
- Physician assistants;
- Psychiatrists;
- Psychiatric nurse practitioners; and
- Psychologists.

IMPORTANT: A provider can be a covered provider type but not a network provider. Call American Behavioral at 1-800-677-4544, and one of our associates will assist you with finding an in-network provider.

All network providers are covered provider types. If you see an out-of-network provider that is not a covered provider type, the *Plan* will not pay for any of the services received. As with all noncovered services, any payments you make to a noncovered provider type will not apply toward your deductible or out-of-pocket limit.

What You Pay for Behavioral Health Services

What Is Co-insurance?

Co-insurance refers to the percentage of the allowed amount that you pay for most services

when the *Plan* pays less than 100% of the allowed amount.

NOTE: See your *Summary of Mental Health and Substance Abuse Benefits* included with this *Handbook* for specific co-insurance amounts.

What Is a Copayment?

A copayment is a flat dollar amount you pay when you receive services. Depending on the type of service, the copayment may be applied per visit, per day, etc.

NOTE: See your *Summary of Mental Health and Substance Abuse Benefits* included with this *Handbook* for specific copayment amounts.

When Do I Pay?

Copayments are due at the time services are rendered.

Your Behavioral Health Care Benefits

Guidelines for Coverage

The fact that a physician or other provider prescribes, orders, recommends, or provides a service or supply does not mean it is covered. The following section describes benefits provided by this *Plan*. Be sure to read it carefully for important information that can help you get the most from your behavioral health coverage.

For the *Plan* to cover a service, it must meet all of the following conditions. The service is:

- Listed as covered;
- Medically necessary; and
- Consistent with the *Plan's* coverage policies and precertification requirements.

Even if a specific benefit is not covered, you and your provider may decide that the care and treatment are necessary. You and your provider are responsible for making this decision.

List of Benefits

Mental Health and Substance Abuse Services

Mental illnesses are serious disorders that can affect your thinking mood and behavior. There are many causes of these disorders. Your genes and family history may play a role, as well as life experiences, such as stress or a history of abuse. Biological factors can also play a role in mental illness.

Chemical dependency is a chronic, progressive disease which, if left untreated, can lead to life-threatening health problems and premature death. Chemical dependency also causes severe problems in other life areas, such as the familial, psychological, emotional, social, vocational, and spiritual aspects.

The following benefits are provided to address mental illnesses and substance abuse:

Personal Care Management for Complex Health Care Needs

Care management is a service offered by the *Plan* to assist you with your behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns.

This voluntary service helps you navigate the health care system and evaluate your health care goals. Your personal care manager helps you by identifying issues and barriers that may prevent you from getting better, as well as providing motivational support for chronic behavioral and/or medical conditions.

Call American Behavioral at 1-800-677-4544 to talk to your personal care manager.

Co-occurring Disorders

Programs are available for the treatment of co-occurring disorders. Formerly known as dual diagnosis, co-occurring disorders describe the presence of one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders.

Crisis Assessment

Crisis assessment is an immediate, face-to-face assessment by a mental health professional during an urgent situation. The assessment helps identify any need for emergency services, crisis intervention, or referrals to other resources.

Day Treatment/Partial Hospitalization Program (PHP) Services

The *Plan* covers PHP services, which are provided <u>while you reside in your community</u> and not as part of a 24-hour-per-day program. PHP services include nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, substance abuse evaluation and counseling. This highly structured level of treatment includes up to eight (8) hours of clinical services per day.

Facilities providing PHP services must be licensed by the state and accredited and certified by an appropriate, nationally-recognized accrediting agency.

NOTE: Precertification is required for PHP services.

Electroconvulsive Therapy (ECT)

ECT treatments are administered by a specially trained psychiatrist for a therapeutic effect. ECT treatments are provided in an outpatient facility or, when necessary, during an acute inpatient hospitalization.

NOTE: Precertification is required for ECT.

Inpatient Hospitalization

Acute inpatient hospitalization includes structured treatment services and 24-hour on-site nursing care and monitoring. You can expect an evaluation by a psychiatrist within the first 24 hours of the admission. Daily, active treatment by a psychiatrist supervising the plan of care is required.

Services are considered "inpatient" when you spend the night in a hospital. Inpatient treatment is provided in a secure, protected hospital setting, and is indicated for stabilization of individuals displaying acute mental health and/or substance abuse conditions.

Facilities providing inpatient services must be licensed by the state and accredited and certified by an appropriate, nationally-recognized accrediting agency.

NOTE: Precertification is required for inpatient mental health services.

Inpatient Substance Detoxification

Inpatient substance detoxification is a serious medical process usually taking 3-5 days. Detoxification is aided by medications that prevent severe complications.

Facilities providing inpatient substance detoxification services must be licensed by the state and accredited and certified by an appropriate, nationally-recognized accrediting agency.

NOTE: Precertification is required for inpatient substance detoxification services.

Inpatient Catastrophic Hospitalization

A catastrophic hospitalization involves a chronic condition for which long-term stabilization is needed, as indicated by a length of stay greater than 12 days.

IMPORTANT: Some hospital-based physicians who work in a network hospital or other facility may not be network providers. If an out-of-network provider bills separately from the hospital, and his or her billed charges are more than the allowed amount, you may be billed for the difference in addition to your co-insurance.

NOTE: Pre-admission certification is required for all hospital admissions except emergency hospital admissions. For emergency hospital admissions, American Behavioral must receive

notification within 48 hours of admission. Please see the *Limits on Plan Coverage* section of this *Handbook* and the *Summary of Mental Health & Substance Abuse Benefits* included with this *Handbook* for additional information.

Intensive Outpatient Program (IOP) Services

The *Plan* covers IOP services which are provided while you reside in your community and not as part of a 24-hour-per-day program. Treatment in an IOP includes individual therapy, group therapy, family and/or multi-family therapy and psycho-education to decrease symptoms and improve your level of functioning. Depending on the structure of the program, IOP occurs up to five (5) times per week for up to four (4) hours each session.

Facilities providing IOP services must be licensed by the state and accredited and certified by an appropriate, nationally-recognized accrediting agency.

NOTE: Precertification is required for IOP services.

Medication Management

Medication management is a service to determine your need for a prescribed drug, or to evaluate the effectiveness of the prescribed drug as noted in your written individual treatment plan. It is provided by psychiatrists or nurse practitioners specializing in treating mental disorders using the biomedical approach.

NOTE: Please see your prescription coverage for the cost of specific medications.

Office Visits

These are services provided at an office location other than the following:

- Hospital;
- Skilled nursing facility (SNF);
- Military treatment facility;
- Community health center; or
- A state or local public health clinic.

Psychological and Neuropsychological Testing

Psychological testing is a process that uses a combination of techniques to help arrive at a diagnosis based on your behavior, personality, and capabilities, while neuropsychological testing includes specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway.

IMPORTANT: Both psychological and neuropsychological tests must have sound psychometric properties including empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data based on age, educational attainment, and when

relevant ethnicity and gender.

IMPORTANT: Psychological and neuropsychological testing must be performed by a qualified health professional.

NOTE: Notification is required for psychological and neuropsychological testing if more than eight (8) hours are requested within one (1) session.

Psychotherapy

Psychotherapy is covered when it is provided by a licensed behavioral health provider in order to treat a mental health or substance abuse disorder. Brief, goal-directed talk therapy may be implemented for individuals, groups, and families.

Pre-certification and Notification

"Pre-certification" is when your provider sends a request for coverage of a service before it occurs, and the *Plan* sends either an approval or denial of coverage. If services that require precertification are not approved before being provided, no benefits will be payable for the admission or the services provided by the admitting physician.

Receiving precertification does not necessarily mean that the services you receive are covered. For example, your admission may relate to a benefit that is excluded from coverage. "Notification" means that your provider must contact the *Plan* to let us know when you receive services.

FOR MORE INFORMATION: If you have a question concerning benefits, the interpretation of this document, and/or precertification/notification requirements, call American Behavioral at 1-800-677-4544.

What the *Plan* Does Not Cover

This *Plan* covers only the services and conditions specifically identified in this *Mental Health and Substance Abuse Benefits Handbook*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered, even if your provider says the services are medically necessary. Non-covered services are known as "exclusions."

General Exclusions

A

1. **Achievement testing**
2. **Acupressure or acupuncture**

3. Provider **administrative fees, including,** but not limited to, charges for any of the following:

   - Completing forms, including claims
   - Copying records
   - Report preparation
   - Finance charges
   - Obtaining medical records
   - Completing a treatment report
   - Late payment charges

4. **Alternative therapy** or treatment methods that do not meet national standards for behavioral health practice, including, but not limited to:

   - Personal growth and development
   - Regressive therapy
   - Neuro-feedback
   - Neuro-biofeedback
   - Hypnotherapy
   - Homeopathic medicine
   - Massage therapy
   - Reiki
   - Thought-field Energy
   - Art or dance therapy
   - Marathon therapy
   - Motivational training

5. **Animal-assisted therapy** (e.g. equestrian therapy)
6. **Applied Behavior Analysis (ABA)** *(See your medical plan document for ABA coverage.)*
7. **Aroma therapy**
8. **Aversion therapy**

B

1. **Biofeedback**
2. **Bio-energetic therapy**

C

1. **Carbon dioxide therapy**
2. **Chelation Therapy,** except in the treatment of conditions considered medically necessary, medically appropriate and not experimental or investigational for the condition for which the treatment is recognized
3. Any services or expenses for which a **claim is not properly submitted**
4. **Claims** received later than 24 months from the date of service
5. Any services or expenses incurred during treatment provided primarily for **clinical trials**, medical or other research
6. Any services or expenses for treatment of mental health or substance abuse conditions that by Federal, state or local law must be treated in a public facility, including, but not limited to, **commitments for mental illness**
7. **Confrontation therapy**
8. Any services or expenses incurred during the course of **convalescent care**
9. Any services or expenses incurred during the course of **court-ordered treatment**, unless it is determined that such services are medically necessary based on medical

necessity criteria for the purpose of treating a mental health or substance use disorder, and there is reasonable expectation of improvement of the patient's condition or level of functioning

10. Services delivered by providers not listed as **covered provider types** (See the section of this *Handbook* entitled *Finding a Behavioral Health Care Provider,* subsection *Covered Provider Types*)
11. Any services or expenses for treatments that are not otherwise **covered services**. Examples include, but are not limited to, when such services or expenses related to the following:

- Adoption
- Camp
- Career
- Custodial evaluation
- Education
- Employment
- Forensic evaluation
- Insurance
- Marriage
- Medical research
- Obtaining or maintaining a license of any type
- Sports
- Travel
- Wilderness programs

12. **Crystal healing therapy**
13. Any services or expenses incurred during the course of **cult deprogramming**
14. Any services or expenses incurred during the course of **custodial care** or supportive counseling, including care for conditions not typically resolved by treatment

D

1. Any services or expenses related to treatment provided for **dental, medical, or psychiatric care** not routinely required in the course of chemical dependency treatment
2. Any services or expenses related to **disabilities related to military service** for which the member is entitled to service and for which facilities are reasonably available to the member
3. Any services or expenses incurred during the course of **domiciliary care**
4. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills

E

1. Any services or expenses related to non-psychiatric therapy or **education** for autism, intellectual disability (formerly mental retardation), learning disabilities/disorders, or developmental disorders, including social skills training
2. **Educational or professional growth training** or certification related to employment
3. Any services that are primarily to assess or address **remedial educational disorders**, including, but not limited to, materials, devices, and equipment to diagnose or treat learning disabilities

4. Any services or expenses incurred during the course of investigative services related to **employment**
5. Any services or expenses incurred in order to obtain or maintain **employment**
6. Services, care or treatment received after the **ending date of the member's coverage**
7. **Excess Charges,** which are charges or the portion thereof which are in excess of the allowed amount, the negotiated rate or fee schedule
8. **Experimental, Investigational or Unproven** means any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

    - Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
    - Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
    - Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
    - Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

    Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational or Unproven.

    Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.
9. **Expressive therapies** (e.g. psychodrama) when billed as a separate service

F_____

Any services or expenses incurred during the course of therapeutic **foster care**

G

1. Services furnished by or for the US **government**, Federal and State funded agency or a foreign government, unless payment is legally required
2. Services applied under any **government program** or law under which the individual is covered

H

1. Any services or expenses incurred during the course of treatment provided in a **halfway house** or other sober living arrangement
2. Any services or expenses related to **hearing impairment**
3. **Hemodialysis** for schizophrenia
4. Any services or expenses related to **holistic** medicine
5. Any services or expenses incurred during the course of **extended hospital stays** that are unrelated to medically necessary and approved treatment
6. **Hyperbaric therapy** or other oxygen therapy

I

1. Any services or expenses required while the member is **incarcerated** in a prison, jail, or any other penal institution
2. Any services or expenses incurred during the course of **inpatient treatment** for co-dependency, gambling, and sexual addiction
3. **Insight-oriented therapy**
4. Services administered for **insurance** purposes
5. **Intelligence quotient (IQ) testing**
6. Any services or expenses incurred during treatment of conditions not classified in the *Mental, Behavioral and Neurodevelopmental Disorders* section of the ***International Classification of Diseases***, as periodically updated

J

Any services or expenses related to **judicial** or administrative proceedings

L

1. **Laboratory tests**
2. Services for which you have no **legal obligation to pay** or for which a charge would not ordinarily be made in the absence of coverage under this *Plan*
3. Services provided by someone **not licensed** by the State to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review
4. Services and expenses provided to a member that could have been provided at a **lower level of care** based on medical necessity criteria and given the member's condition and the services provided (e.g. an inpatient admission that could have been treated on an outpatient basis)

M

1. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services
2. **Marriage therapy**
3. Any services or expenses incurred during care that is not deemed **medically necessary** or that is not a covered service even if prescribed, recommended, or approved by your provider
4. When Medicare is primary, any services, expenses, or supplies to the extent that you are or would be, entitled to **Medicare reimbursement**, regardless of whether you properly and timely applied for, or submitted claims to Medicare, except as otherwise required by Federal law
5. Over-the-counter or prescription **medication** (See your Medical Plan for information concerning prescription medication coverage)
6. The *Plan* shall not be responsible for charges incurred for **missed appointments**

N

1. Any services or expenses related to **narcotic maintenance therapy**
2. **Neuropsychological testing** that is not conducted by a qualified health professional.
3. **Neuropsychological testing** is not a covered benefit when undertaken for medical diagnosis of a neurological disorder, traumatic brain injury, stroke, closed head injury, dementia; for the diagnosis of attention deficit disorders; for legal reasons such as competency to handle business affairs, disability applications or Workers' Compensation claims. Testing under those conditions should be billed under medical insurance or paid for by other entities such as Workers' Compensation. Neuropsychological testing may be a covered benefit in cases where clear confusion exists as to whether a symptom pattern reflects a psychiatric problem as opposed to a neurological pattern
4. Therapy services or expenses of any kind for **nicotine addiction** (e.g. smoking cessation treatment)
5. **Nutritional therapy** (registered dietician)

O

Occupational therapy

P

1. **Pastoral counseling**
2. Some services may be excluded if not **precertified**
3. **Pharmaceutical preparations** except as given in an inpatient setting and included in a predetermined hospital per diem or case rate
4. **Physical therapy**
5. **Primal therapy**
6. Any services or expenses incurred during the course of **private duty nursing**

7. Services delivered by **providers delivering services outside the scope of their licenses**
8. Any services or expenses incurred during treatment performed by a **provider for a member who is related to the provider** by blood or marriage or who regularly resides in the provider's household
9. **Psychoanalysis**
10. **Psychological testing** that is not conducted by a qualified health professional.

11. **Psychological/neuropsychological testing,** except when conducted for purposes of diagnosing a mental disorder or when rendered in connection with treatment for a mental disorder
12. **Psychological/neuropsychological testing** without sound psychometric properties including empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data based on age, educational attainment, and when relevant ethnicity and gender
13. **Psychological/neuropsychological testing** administration, scoring, and interpretation that is above and beyond the time limit(s) reported in peer review publications
14. **Psychological/neuropsychological testing** in which the provider does not compose a final report that, at minimum, summarizes clinical impressions and recommendations that will be forwarded to the referring provider and discussed with you
15. **Psychological/neuropsychological testing** that is not relevant and valid for evaluating the clinical concerns under consideration
16. **Psychological/neuropsychological testing** that is not otherwise a covered service. Examples of such excluded testing include when such services relate to career, education, sports, camp, travel, employment, insurance, marriage, adoption, medical research, or to obtain or maintain a license of any type

R

1. **Radiological imaging** conducted in order to find the cause of an organic disorder, e.g. CT scan, MRI, etc.
2. **Recreation therapy**
3. Treatment in a **residential facility.**
4. Any services or expenses incurred during **respite care**
5. Any services or expenses incurred during **rest cures**
6. **Rolfing**

S

1. Any services or expenses incurred during care that is provided in a **school**
2. **Sedative action electro-stimulation therapy**
3. **Sensitivity training**
4. **Self-help training**
5. Any services or expenses incurred for treatment of **sex offenders**
6. Any services or expenses related to **sleep diagnostic clinics**
7. **Speech therapy**
8. **Stress management**
9. Any services or expenses incurred during **substance abuse treatment** that is not abstinence-based

10. Any services or expenses incurred during **substance abuse treatment** for licensed, registered or certified professionals that is not deemed medically necessary or is beyond the scope of benefits as outlined in the *Summary of Mental Health and Substance Abuse Benefits* when recommended or required to maintain a professional license, certification or registration

T

1. Any services or expenses incurred during **telephone,** email, and Internet consultations in the absence of a specific benefit
2. **Transcendental Meditation**
3. **Travel, transportation, and lodging expenses** incurred in order to receive consultation or treatment, even if the treatment is recommended, prescribed, or provided by your provider
4. Any services or expenses incurred during treatment provided when the **treatment plan** does not meet clinically accepted standards of care
5. **Tryptophan therapy**

V

1. **Vitamin (megavitamin) therapy**
2. Any services or expenses related to **vision impairment**

W

1. Any services or expenses received while on active military duty or as a result of **war or any act of war,** whether declared or undeclared, terrorism, participation in a riot, insurrection, rebellion, or direct participation in an act deemed illegal by a court of law
2. Any services or expenses for conditions that require coverage to be purchased or provided through other arrangements such as **Workers' Compensation, no-fault automobile insurance** or similar legislation

Diagnostic Exclusions

NOTE: The diagnostic exclusions listed are not all-inclusive.

1. Services or expenses of any kind for **caffeine intoxication**
2. Services or expenses of any kind related to **eating disorders,** including, but not limited to, anorexia nervosa and bulimia nervosa
3. **Developmental delays:** Occupational, physical, and speech therapy services related to developmental delays, intellectual disability or behavioral therapy that are not medically necessary and are not considered by the *Plan* to be medical treatment. If another mental health or substance abuse condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to *Plan* provisions
4. **Intellectual disability** as the primary diagnosis except for the purpose of making the initial diagnosis

5. **Communication disorders** as the primary diagnosis, except for making the initial diagnosis. Such disorders include, but are not limited to, language disorder, mixed receptive-expressive language disorder, speech sound disorder, and stuttering.
6. **Learning disability:** Non-medical treatment, including but not limited to special education remedial reading, school system testing and other rehabilitation treatment for a learning disability. If another mental health or substance abuse condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to *Plan* provisions
7. **Motor disorders** as the primary diagnosis, except for making the initial diagnosis.
8. **Truancy, disciplinary, or other behavioral problems** as the primary diagnosis.

If You Have Other Coverage

Coordination of Benefits

Coordination of benefits applies when you have coverage under this benefit package and one or more other benefit plans. The coordination of benefits provisions in this section apply to the benefits described in this *Handbook*. Separate coordination of benefits rules may apply to other benefits provided by your employer through its group health plan.

NOTE: In order for American Behavioral to determine which plan is primary, you are required to notify the *Plan* about any other behavioral health care coverage you have in addition to the coverage provided by the *Plan*.

NOTE: If you have questions concerning coordination of benefits, call American Behavioral at 1-800-677-4544.

Workers' Compensation

Compensation is dependent on your employer's Workers' Compensation benefit.

Benefit Determinations

American Behavioral and the other plan(s) providing benefits shall determine which plan is primarily responsible for payment of covered benefits (e.g. the primary plan). If the *Plan* is primary, only those services outlined in this *Handbook* are covered services. If your other plan is primary, the *Plan* is secondary. The other plan must, therefore, pay up to its maximum benefit level after which the *Plan* shall pay for any remaining expenses subject to the following provisions:

- The total combined payment by the *Plan* and any other plan to you or on your behalf shall not exceed the maximum amount that the *Plan* would pay if it were primary
- The *Plan* shall not cover services rendered to you that were denied by the primary plan due to your failure to comply with its terms and conditions, except when such services were provided by or under the care of a network provider.
- The *Plan* shall not be liable for payments for any services or supplies that are not covered

services as outlined in this *Handbook*. All requirements must be met in order for services to be covered services even when the *Plan* is secondary.
- Benefits will only be paid when covered services are provided by network providers, or when the *Plan* has an out-of- network coverage benefit.

Which Plan is Primary?

The rules determining whether the *Plan* or another plan is primary will be applied in the following order:

- The noncompliant plan or the plan having no coordination of benefits provision or non-duplication of coverage exclusion shall always be primary. A noncompliant plan has coordination of benefits rules that are not consistent with the order of benefit determination rules of this Plan, e.g. a plan that states its benefits are always secondary.
- The plan covering a member who is the subscriber is the primary plan. In addition, the benefits of a plan that covers a member as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree about benefits, this provision is ignored.
- The following is known as *The Birthday Rule*: The plan of the parent whose birthday comes first in the calendar year shall be primary with respect to dependent coverage. The year of birth is ignored. This rule is subject to the following rules for divorced or separated parents:

    - If the parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period.
    - If there is a court decree that establishes financial responsibility for medical, dental, or other health care expenses for the child, the plan covering the child as a dependent of the parent who has the responsibility will be primary.
    - If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
    - In the absence of a court decree, the plan of the parent with legal custody will be primary.
    - If the parent with custody has remarried, the order of benefits will be:

        - The plan of the parent with custody;
        - The plan of the stepparent with custody;
        - The plan of the parent without custody; and
        - The plan of the stepparent without custody.

- If none of the above rules determine the order of benefits, the benefits of the plan that covered a member or subscriber longer are determined before those of a plan that covered that person for the shorter time.

How Does American Behavioral Pay When They Are Primary?

When American Behavioral is the primary payer (pays first), American Behavioral pays its normal benefit (as described in this *Handbook*). You may need to send the American Behavioral *Explanation of Benefits* (EOB) and a copy of your provider's bill to your secondary payer to receive payment. Check with that plan for more information.

What Happens When Medicare is Secondary to American Behavioral?

NOTE: When Medicare pays after American Behavioral, your provider must bill Medicare after American Behavioral pays; American Behavioral does not bill Medicare.

If American Behavioral is your primary coverage and Medicare is secondary, make sure that you tell Medicare about your American Behavioral coverage and that your provider agrees to bill Medicare as secondary to get the maximum benefit from both plans. The provider would need to bill Medicare after American Behavioral has processed the claim.

NOTE: For more detailed information concerning how the *Plan* coordinates benefits with Medicare, see the *Coordination of Benefits* section of the health plan *Summary Plan Description*.

How Does American Behavioral Coordinate Benefits When They Are Secondary?

It is not intended that payments made for services rendered to you shall exceed one hundred percent (100%) of the cost of the services provided. Therefore, American Behavioral pays only an amount needed to bring the total benefit up to the amount the *Plan* would have paid if you did not have other coverage. This is called nonduplication of benefits.

If duplicate coverage occurs, the *Plan* may recover from you or from any other plan under which you are covered proceeds consisting of benefits payable to you or on your behalf, up to the amount of the *Plan's* cost obligation for covered services.

Billing & Payment: Filing a Claim

Submitting a Claim for Behavioral Health Services

When American Behavioral is your primary coverage and your provider is in network, you do not need to submit claims. The provider will do it for you.

FOR MORE INFORMATION: If you have a question about whether your provider's office has submitted a claim, call the American Behavioral Claims Department at 1-800-677-4544.

When Do I Need to Submit a Claim?

You may need to submit a claim to American Behavioral for payment if you receive services

from an out-of-network provider or if you have other coverage that pays first and American Behavioral is secondary.

How Do I Submit a Claim?

NOTE: You can access the *Behavioral Health Reimbursement Form* in the *Members* section of www.americanbehavioral.com or call American Behavioral at 1-800-677-4544 for a copy.

To submit a claim yourself, you will need to obtain and mail the following documents:

- The *Behavioral Health Reimbursement Form*;
- The provider claim document;
- Your receipt; and
- If applicable, the *Explanation of Benefits* (EOB) from the primary payer.

Be sure to make copies of your documents for your records and mail the original documentation to the attention of "Claims." If you have a question about the processing of your claim, call the American Behavioral Claims Department.

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address and telephone information.

Information About Submitting Claims

IMPORTANT: You or your provider must submit claims within 180 days from the date you received health care services; this is called the *timely filing* deadline. The *Plan* will not pay claims submitted more than 180 days after the date of service.

What You Need to Know as a *Plan* Member

Your Rights and Responsibilities

Through American Behavioral, you have the following rights and responsibilities:

Your Rights

American Behavioral believes that you have the right to:

- Be treated with dignity, respect and courtesy;
- Be treated without regard to race, religion, gender, sexual orientation, ethnicity, age, disability or communication needs;
- Confidentiality of protected health information and treatment information;
- Receive information about American Behavioral services, providers, clinical guidelines, quality improvement programs, member rights and responsibilities and any other rules or guidelines used in making coverage and payment decisions;
- A clear explanation of your health plan benefits and how to access services;

- Access to services and providers that meet your needs;
- Choose or change your provider;
- Request an interpreter or assistance for language translation or hearing problems;
- Participate in making your health care decisions by receiving appropriate information about your diagnosis, treatment options and prognosis;
- Participate in decisions concerning your care and treatment plan;
- An individualized treatment plan that is periodically reviewed and updated;
- Refuse or consent to treatment or tests to the extent provided by law and be made aware of the medical consequences of such decisions;
- Refuse to participate in any proposed investigational studies, clinical trials, or research projects;
- Receive treatment within the least restrictive environment;
- Be informed of the reason for any adverse determination by American Behavioral utilization management, including the specific utilization review criteria or benefits provision used in the determination;
- Utilization management decisions based on appropriateness of care. American Behavioral does not reward providers or other individuals conducting utilization review for issuing adverse determinations;
- Submit either positive or negative comments concerning your care to American Behavioral, your health care provider(s), or your employer;
- Information about how to file a formal complaint or appeal;
- Voice complaints regarding use or disclosure of protected health information;
- Receive a copy of these rights and responsibilities;
- Make recommendations regarding these rights and responsibilities; and
- To appoint your next of kin, a legal guardian or legal designee to exercise these rights if you are unable to do so.

Your Responsibilities

American Behavioral believes that you have the responsibility to:

- Know your health plan benefits and adhere to the guidelines of your policy;
- Provide an accurate medical and social history. This includes granting a release of medical records from former providers, if needed;
- Respect the rights, privacy, and confidentiality of other patients and their families;
- Gather and carefully consider all information needed to give consent for treatment or to refuse care;
- Cooperate with the agreed upon treatment plan, instructions and guidelines, and to discuss the results with your Provider;
- Notify your health care Provider when you expect to be late for an appointment or need to cancel;
- Ask questions regarding your illness or treatment and to tell your provider about your expectations of treatment;
- Provide a copy of your "advanced directives" to your provider whenever changes are made; and
- Promptly pay any applicable copayments, co-insurance, and deductibles.

Your Right to Information

We support the goal of giving you and your family the detailed information you need to make the best possible behavioral health care decisions. You can find the following information in this *Handbook:*

- A list of covered expenses;
- Benefit exclusions, reductions, and maximums or limits;
- A clear explanation of complaint and appeal procedures;
- A uniform glossary of terms (UGI); and
- The process for pre-authorization or review.

You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

American Behavioral does not prevent or discourage providers from telling you about the care you require, including various treatment options and whether the provider thinks that care is consistent with coverage criteria. You may, at any time, get health care outside of *Plan* coverage for any reason; however, you must pay for those services and supplies. In addition, the *Plan* does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of Your Health Information

American Behavioral follows its *Privacy Policy,* which is available online at www.americanbehavioral.com or by calling us at 1-800-677-4544. The *Plan* will release member health information only as described in that notice or as required or permitted by law or court order.

Notice of Nondiscrimination

American Behavioral complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

American Behavioral:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as qualified interpreters and in formation written in other languages

If you need these services, contact American Behavioral at 1-800-677-4544. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by fax.

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address, telephone, and fax information.

Send grievances to the attention of Compliance & Quality Improvement. When initiating a grievance by fax, please use the Clinical Services fax number.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Service
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Requests for Medical Records or Billing Statements

You may contact your provider to request complete listings of medical records or billing statements pertaining to you. Providers may charge a fee to cover the cost of providing records or completing requested forms.

Complaints

Types of Complaints

Inquiry: An inquiry is the act of requesting information or a close examination of facts or evidence. Inquiries are not subject to appeal.

Quality of Care Complaint: A quality of care complaint is a report of behavior that could adversely impact your health and wellbeing. Quality of care complaints are not subject to appeal.

Complaint Procedure

To submit a verbal complaint, call American Behavioral, and we will assist you with the

specific process. To submit a written complaint, mail all pertinent documentation the attention of "Quality Management."

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address and telephone information.

American Behavioral reserves the right to require that complaints be submitted in writing, depending on the nature of the allegation.

Your Claims and Appeals Rights

This section explains the rules for filing claims and appeals.

Claims

Claims for benefits under the *Plan* can be post-service, pre-service, or concurrent. This section of the *Handbook* explains how these claims are processed and how you can appeal a partial or complete denial of a claim. You must act on your own behalf or through an authorized representative.

Post-Service Claims

For you to obtain benefits after services have been rendered, we must receive a properly completed claim form from you or your provider. Most providers are aware of our claim filing requirements and will file claims for you.

NOTE: If your provider does not file a claim form for you, then you can go to the *Members* section of www.americanbehavioral.com and download the *Behavioral Health Reimbursement Form or* call American Behavioral and ask for a copy.

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for our telephone numbers.

The following information should be included with the *Behavioral Health Reimbursement Form:*

- The provider claim document;
- Your receipt; and
- If applicable, the *Explanation of Benefits* (EOB) from the primary payer.

When you have completed the *Behavioral Health Reimbursement Form,* send it and other pertinent documentation to the attention of "Claims."

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address information.

Claims must be submitted and received by us within 180 days after the service takes place to be eligible for benefits.

Pre-Service Claims

Mental health and substance abuse services must meet established medical necessity guidelines. You or your authorized representative may call us before services are received at 1-800-677-4544. American Behavioral is available 24-hours-per-day, seven-days-per-week.

Concurrent Care Determinations

If we have previously approved a course of treatment to be provided over a period of time or number of treatments, and the course of treatment is about to expire, you may submit a request to extend your approved care. The phone number for requesting an extension of care is 1-800-677-4544.

Your Right to Information

Upon request, you have the right to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

You or your authorized representative may appeal (either verbally or in writing) any adverse benefit determination. An adverse benefit determination includes any of the following:

- Any determination that we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your Provider;
- Our denial of a pre-service claim;
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or
- An adverse medical necessity decision.

Either an urgent/expedited appeal or a non-urgent/standard appeal can be requested. An urgent/expedited appeal can be requested if a delay in treatment would result in:

- A significant increase to the risk of your health or the health of others;
- Severe pain; or
- The inability to regain maximum functioning.

How to Initiate an Internal Appeal Review Through American Behavioral

IMPORTANT: American Behavioral does not perform retrospective medical necessity review. You or your authorized representative my file a standard appeal for payment after services have been rendered. You must request an appeal within 180 calendar days from the receipt date of our letter that contained the adverse determination decision.

You or your authorized representative may initiate an appeal by calling American Behavioral or submitting the documentation in writing to the attention of "Appeals."

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address, telephone, and fax information. Please use the Clinical Services fax number when initiating an appeal by fax.

The appeal request should include all of the following:

- The member's name;
- The member's date of birth;
- An identification number, if applicable;
- The date(s) of service(s);
- The name of the treating provider;
- Any additional information to be considered during the appeal process. Information that can be included in an appeal includes:
- Records relating to the current conditions of treatment;
- Notation of coexisting conditions; and
- Any other relevant information.

Appeal Review Process

American Behavioral has two levels of appeal. The non-urgent/standard appeal is the final level of appeal. You may request a non-urgent/standard appeal if a previously filed urgent/expedited appeal resulted in an adverse determination.

You must request an appeal within 180 calendar days from the receipt date of our letter that contained the adverse determination decision.

Urgent Process (Expedited Appeal)

You or your provider(s) may request an expedited appeal by calling 1-800-677-4544. We will review the urgent appeal, render a decision, and notify you and your provider(s) within 48 hours of the appeal request.

Additional Rights

You may request, free of charge, a paper copy of any relevant documents, records, guidelines or other information we used to make our decision. You can call American Behavioral or submit your request in writing, sending the documentation to the attention of "Appeals."

IMPORTANT: See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook* for address, telephone, and fax information. Please use the Clinical Services fax number when requesting information by fax.

Some information will require you to provide a written request or consent before it can be released.

FOR MORE INFORMATION: If you have any questions about appeals or complaints, contact American Behavioral using the contact information listed in the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook*.

NOTE: Appeals procedures are subject to change during the year if required by federal or Alabama State law.

You may request an appeal yourself, or an authorized representative may request an appeal for you. There are three parts to the appeals process: first-level appeal, second-level appeal, and external or independent review.

If your request involves a decision to change, reduce, or terminate coverage for services already being covered, the *Plan* must continue coverage for these services during your appeal. However, if the *Plan* upholds the decision to change, reduce, or terminate coverage, you will be responsible for any payments made by the *Plan* during that period. If you request payment for denied claims or approval of services, not yet covered by the *Plan*, we do not have to cover the services while the appeal is under consideration.

The *Plan* will consult with a health care professional on appeals where the *Plan's* decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment is experimental, investigational, or not medically necessary or appropriate. In this case, the *Plan* will consult with a health care professional who has appropriate training and experience in the field of behavioral health care involved.

You may send written comments, documents, and any other information when you request an appeal. You may also request copies of documents the *Plan* has that are relevant to your appeal, which the *Plan* will provide at no cost. Our review will consider any information you or your provider submits to us.

How to Designate an Authorized Representative

IMPORTANT: Because of privacy laws, the *Plan* usually cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or the *Plan* has received written authorization to release personal health information to the other person. If you want to authorize someone to receive your protected health information or designate a representative, you may request an *Authorization to Disclose Protected Health Informati*on from American Behavioral. This form must be completed and returned to American Behavioral before we can share information. If you are designating someone else to represent you in an appeal or complaint, the form must specifically state this.

In most cases, American Behavioral must have written authorization to communicate with anyone but the enrollee (patient) except when the enrollee is under age 14; a parent or legal guardian may act as representative.

Under some circumstances, written authorization is necessary when the enrollee is age 14 to 17. You may choose to authorize a representative to:

- Talk to American Behavioral about claims or services;
- Share your protected health information; and/or
- Handle an appeal on your behalf.

To designate an authorized representative, you must complete an *Authorization to Disclose Protected Health Information* form, available by calling American Behavioral at 1-800-677-4544 or through www.americanbehavioral.com. Send the form to the address on the form. American Behavioral cannot share information or proceed with an appeal until we receive the completed form. On the form, you must specify:

- What information may be disclosed;
- The purpose of the disclosure (for example, handling an appeal on your behalf); and
- Who is designated to receive or release the information.

External or Independent Review

You may request an external or independent review only when the denial is based on one of the following:

- Medical necessity;
- Appropriateness;
- Health care setting;
- Level of care; and/or
- Effectiveness of a covered benefit.

If you have gone through both a first- and second-level appeal and your appeal was based on one of the issues listed above, you may request an external or independent review in the following situations:

- If the *Plan* has exceeded the timelines for response to your appeal without good cause and without reaching a decision;
- If you are dissatisfied with the decision of your second-level appeal.; and/or
- If the *Plan* has failed to strictly adhere to the requirements of the appeals process.

You must request an independent review no more than 180 days after the date of the letter responding to your second-level appeal. The enrollee or an authorized representative can request an independent review.

To request an external or independent review, contact the *Plan* by telephone or you can submit your request in writing. (See the *Birmingham Corporate Headquarters* portion of the *Important Contact Information* section of this *Handbook*.)

American Behavioral will send the relevant medical information and correspondence to the independent review organization.

You may pursue litigation against American Behavioral

- Instead of requesting an independent review;
- After an independent review decision; and
- When your appeal is not eligible for an independent review.

An external review determination is binding unless other remedies are available under state or federal law. If a final external review determination reverses the *Plan's* decision and you or the *Plan* decides to pursue other remedies available under state or federal law, the *Plan* must provide benefits, including making payment on a claim until there is a judicial decision changing the external review determination.

NOTE: An independent review organization (IRO) will conduct the external review. An IRO is a group of medical and benefit experts qualified to perform the review. These experts are not employed or otherwise related to American Behavioral.

An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the *Plan's* decision is consistent with State law and the *Plan's Mental Health and Substance Abuse Benefits Handbook*. The *Plan* will pay the IRO's charges.

Rights of American Behavioral

Right to Release and Receive Necessary Information

Certain facts about health care coverage and services are needed for determining benefit coverage and coordination of benefits, under this *Plan* and others. We may get the needed information from other organizations or persons for these purposes, or we may give the facts to another organization or person. We are not required to tell or get consent from any person to do this. Each member claiming benefits under this *Plan* must give us any facts needed to make the determinations noted above.

Possible Delay or Denial of Payment

If you do not provide information when we request it, there may be a delay in payment or denial of payment of benefits.

Right to Request Information from Providers

By accepting the mental health and substance abuse services under the *Plan*, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to those services. We have the right to request this information. This applies to all members, including dependents. American Behavioral agrees that such information and records will be considered confidential.

Right to Release Records

We have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the *Plan* for appropriate medical review, quality assessment or as we are required to do by law or regulation.

General Provisions

Recovery Provisions

Refund of Overpayments

If we pay benefits for expenses incurred on your behalf, you or any other person or organization that was paid, must make a refund to us if:

- All or some of the expenses were not paid by you or did not legally have to be paid by you;
- All or some of the payment we made exceeded the benefits under this *Plan*; and
- The refund equals the amount we paid in excess of the amount it should have paid under the *Plan*.

If the refund is due from another person or organization, you agree to help us recover the refund amount when requested.

If you or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the *Plan*. We may also reduce future benefits under any other group benefits plan we administer for the employer. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Right of Subrogation

If we pay or provide any benefits for you under this *Plan,* we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization. In addition, we have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the *Plan,* and for expenses incurred by the *Plan* in obtaining a recovery.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid *Plan* benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in *Plan* benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us from the money that you recover. And, if you are paid by any person or company

besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us from the funds that you recover.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides *Plan* benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You and your attorney must notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this *Plan* to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the *Plan*.

Our Lien Rights

We have a lien against the amount of any money you or your family member recover for an injury or condition for which we have paid *Plan* benefits (including any amounts you recover from another person's insurer or from your own insurer). This lien is for the full amount of the medical expenses we paid on account of the injury caused by the other person. The lien will stay in effect until we have been reimbursed in full from any judgment or settlement obtained, or we agree to waive some or all of the lien. If we have to sue you or your dependent to enforce our lien or to be reimbursed by you or your dependent, you or your dependent will also have to reimburse us for the costs we had to pay to collect the amount you owed us, including our attorney's fees.

Governing Law

The law governing the *Plan* and all rights and obligations related to the *Plan* shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and

obligations related to the *Plan* shall be governed by, and construed in accordance with, the laws of the United States of America and applicable state laws without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the *Plan*.

Transition of Care

What is Transition of Care?

Transition of care coverage allows you to continue receiving services for specified mental health and chemical dependency conditions for a defined period of time with health care professionals who do not participate in the American Behavioral network until the safe transfer of care to a participating professional or facility can be arranged.

You must apply for transition of care either 30 days prior to or no later than 30 days after the effective date of your coverage. Call American Behavioral at 1-800-677-4544 to see if you and/or your dependent(s) are eligible for this benefit.

How Does Transition of Care Work?

- You must already be receiving treatment for the mental health and/or chemical dependency condition.
- If you submit the *Transition of Care Request Form*, American Behavioral will make every effort to get your provider in network, provided he or she meets our credentialing requirements. Call American Behavioral at 1-800-677-4544 to receive a copy of the *Transition of Care Request Form*.
- If transition of care is approved for mental health or chemical dependency conditions, you will receive the in-network level of coverage for treatment of the specific condition by the health care professional for a defined period of time.
- If your plan includes out-of-network coverage and you choose to continue care outside the network beyond the specified time frame, you must follow your plan's out-of-network provisions. This includes any precertification requirements.
- The availability of transition of care coverage does not guarantee that a treatment is medically necessary, nor does it constitute precertification of services to be provided. Depending on the actual request, a medical necessity determination and formal precertification may still be required for a service to be covered.

What is the Allowed Time Frame for Transitioning to a New Participating Health Care Professional?

Usually up to six (6) visits for up to 60 days, depending on the intensity of service or until care has been completed or transitioned to a participating health care professional, whichever comes first.

Can I Apply for Transition of Care If I am Not Currently in Treatment or Seeing a Health Care Professional?

You must already be in treatment for the condition to receive transition of care. However, you may nominate a provider for inclusion in the American Behavioral network, even if you are not currently receiving care. To nominate a provider:

- Use the *Transition of Care Request Form*;
- Go to www.americanbehavioral.com and fill out the online *Provider Nomination Form*; or
- Call American Behavioral at 1- 800-677-4544 for assistance.

How do I Apply for Transition of Care?

Transition of care requests should be submitted 30 days prior to or no later than 30 days after the effective date of your coverage. After receiving your request, American Behavioral will review and evaluate the information provided and will notify you of the decision.

What if I am Not Satisfied?

If you are not satisfied with the transition of care determination, you have the right to appeal the decision. Call American Behavioral at 1-800-677-4544 to initiate the appeals process.

Glossary

Allowable Charge: Any of the following on which the *Plan's* benefits are determined:

- Fee schedule
- Negotiated rate
- Usual and customary rate

The allowable charge may include the fee schedule, negotiated rate or usual and customary, depending on the provider. *See also Fee Schedule and Usual and Customary*.

The allowed amount is the maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses. *See also Balance Billing.*

Appeal: Your request for the *Plan to* review a decision or a grievance again.

Authorized Representative: An authorized representative is someone you have designated in writing to communicate with the *Plan* on your behalf.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100.00, and the allowed amount is $70.00, the provider may bill you for the remaining $30.00. A network provider may

not balance bill you for covered services.

Catastrophic Inpatient Hospitalization: A catastrophic hospitalization involves a chronic condition for which long-term stabilization is needed, as indicated by a length of stay greater than 12 days.

Co-insurance: The percentage of the allowed amount that you pay for most services when the *Plan* pays less than 100% of the allowed amount.

Coordination of Benefits: For members covered by more than one health plan, coordination of benefits is the method the *Plan* uses to determine which plan pays first, which pays second, and the amounts paid by each plan.

Copayment: A fixed dollar amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Covered Provider Type: The *Plan* only covers service provided by providers of certain licensures. Covered provider types under the *Plan* include licensed clinical therapists, neuropsychologists, psychologists, physician assistants, psychiatrists, and psychiatric nurse practitioners. A covered provider type may not be a network provider.

Dependent: A spouse, child, or other eligible family member covered by the *Plan* under the subscriber's account.

Exclusions: Health care services that the *Plan* does not cover.

Explanation of Benefits (EOB): An EOB is a detailed account of each claim processed by the *Plan*, which is sent to you to notify you of claim payment or denial.

Facility: *See Provider, Network Provider,* and *Out-of-Network Provider.*

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any deductible, plan participation rate, copay or penalties that the member is responsible for paying. If a network contract is in place,

the network contract determines the *Plan's* allowable charge used in the calculation of the payable benefit. See also *Allowable Charge* and *Usual and Customary*.

Grievance: A complaint that you communicate to the *Plan*.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Medically Necessary Services: Health care services necessary for diagnosing and treating behavioral health conditions. The necessity of services is determined based on nationally-recognized, evidenced-based medical necessity criteria. These criteria are developed for the purpose of treating mental health or substance use disorders and meet accepted standards of medicine.

Member: A member is an employee, retiree, former employee, or dependent enrolled in the *Plan*.

Network: The facilities and providers the *Plan* has contracted with to provide health care services.

Network Provider: A provider contracted with the *Plan* to provide services to you at an agreed upon reimbursement rate.

Noncovered Services: *See Exclusions.*

Notification: An Instance in which your provider must contact the *Plan* to let us know when you receive certain services. *See also Precertification*

Office Visits: Services provided at an office location other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, or a state or local public health clinic.

Out-of-Network Provider: A provider that is not a participant in the *Plan*'s provider network. The *Plan* has no contracted reimbursement rate with an out-of-network provider, so you will be responsible in part or in full for the cost of the services provided.

Physician Services: Health care services coordinated and/or provided by a licensed medical doctor (MD) or doctor of osteopathic medicine (DO).

Plan Year: A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.

Pre-certification: An instance in which your provider sends a request for coverage of a service before it occurs, and the *Plan* sends either an approval or denial of coverage. If services that require precertification are not approved before being provided, no benefits will be payable for the admission or the services provided by the admitting physician. Precertification of a requested service or treatment is not a promise that the *Plan* will cover the cost. For example, the service(s)/treatment you receive may relate to a benefit that is excluded from coverage. *See also Notification*

Primary Plan: A plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules or its rules differ from those permitted by this regulation; or
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules, the plan determines its benefits first.

Provider: A licensed physician (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine) or health care professional who is licensed and/or certified by Federal and/or State law. A health care facility is a provider that is licensed by Federal and/or State law and accredited by The Joint Commission or CARF.

Secondary Plan: A plan that is not a primary plan. See also *Primary Plan*.

Usual and Customary: The amount determined to be the reasonable charge for comparable services, treatment, or materials in a geographical area. In determining whether charges are usual and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. The *geographical area* is a zip code area or a greater area if the *Plan* determines it is needed to find an appropriate cross-section of accurate data. The usual and customary level is at the 85th percentile. See also *Fee Schedule* and *Allowable Charge/Allowed Amount*.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે □□□□□□□ બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा □□□□□ है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າ ່ າ ທ ່ ານເວ ົ ້ າພາສາ ລາວ, ການບ ໍ ລ ິ ການຊ ່ ວຍເຫ ຼ ືອດ ້ ານພາສາ, ໂດຍບ ໍ ່ ເສ ັ ຽຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero
1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

Summary of Mental Health Benefits for The City of Montgomery

Effective June 1, 2020 **Summary Document #:** 835090364822

IMPORTANT INFORMATION: 1. All benefits are based on the appropriate level of care and medical necessity guidelines. Provider/facility licensure by the state to provide covered services and facility accreditation by The Joint Commission or CARF is required. 2. In-network and out-of-network days/visits/units shall not be combined so that the combination exceeds the total number of days/visits/units available in this section of the *Mental Health and Substance Abuse Benefits Summary*

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) **PHP: One (1)** PHP Day Equals **One (1)** Inpatient Day	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Days 1-3: $100** Per Day Copay • **Days 4-19: Full Coverage** • **Days 20-30: $25** Per Day Copay	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Intensive Outpatient Program (IOP)	**NOT COVERED**	
PROFESSIONAL SERVICES		
• Outpatient Office Visits • Psychological/Neuropsychological Testing **Precertification Required** for Psychological/Neurological Testing if more than **five (5) hours** are requested or **services are provided by an out-of-network provider. Call 800-677-4544** **LIMITATIONS:** Up To **30** Visits/Sessions/ Group Therapy Sessions (Or Any Combination Thereof) Total for Outpatient Mental Health Care **Each Contract Year**	Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Visits 1-5: $5** Copay Per Visit • **Visits 6-20: $20** Copay Per Visit • **Days 21-30: $35** Copay Per Visit	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Inpatient Physician Services in Conjunction with Approved Inpatient Services **LIMITATIONS:** Up To **30** Days Total for Inpatient Mental Health Care **Each Contract Year,** and Up to **60** Days Total for Inpatient Mental Health Care Per Lifetime	Covered At **100%** Of Allowed Amount* **Patient Responsibility: None**	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Anesthesia in Conjunction with Approved ECT Treatment	Covered At **80%** Of Allowed Amount* Subject to the Inpatient Copay Amount **Patient Responsibility: 20%** Of Allowed Amount	Covered At **80%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
COVERED BY MEDICAL PLAN		
• Ambulance • Emergency Dept. • Imaging • Lab Work	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**
BEHAVIORAL HEALTH CARE MANAGEMENT		
Care management is a service offered by *the Plan* to assist you with difficult behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns. Call American Behavioral at 800-677-4544 to talk to your personal care manager.		

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.

Summary of Substance Abuse Benefits for The City of Montgomery

Effective June 1, 2020

Summary Document # 492321101388

IMPORTANT INFORMATION

All benefits are based on the appropriate level of care and medical necessity guidelines.

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization/Substance Detoxification • Partial Hospitalization/Day Treatment (PHP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$500** per Admission Deductible	**NO OUT-OF NETWORK BENEFIT**
Intensive Outpatient Program (IOP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$150** per Admission Deductible	
NOTE: Family program and continuing care services are provided through American Behavioral. Call 800-677-4544 to initiate these services.		

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.